Toil and trouble?

Should residents be allowed to moonlight?

YES

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Moonlighting—also known as limited licensure or restricted registration—is a highly controversial topic among medical residents. It has recently received renewed attention as Ontario launched its pilot program in restricted registration in March 2008. *Moonlighting* is defined as any medical-related professional activity that occurs outside the course and scope of the approved residency or fellowship program that is conducted or arranged by the individual resident or fellow—whether or not he or she receives additional compensation.

Moonlighting is not a return to the old rotating internship and general practice system. It is not a system in which residents are given an unlimited licence to practise. Rather, it represents a licence that is restricted to specialty-specific work in an area of the resident's demonstrated competence and under supervision. This licence is also specific to sites deemed appropriate, ensuring safety to the public while allowing for the provision of services. Eight of 10 Canadian provinces currently provide for and benefit from some form of restricted registration for residents. In those provinces, anecdotal reports suggest it has been used with great success. In the United States, many states allow moonlighting, as does the Accreditation Council for Graduate Medical Education. The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada do not encourage or prohibit moonlighting.

Before the licensure changes of 1993, trainees received a general licence to practise medicine after completing a rotating internship; then they either practised medicine or returned for further training in a specialty. During these years of additional training, many residents worked extra shifts outside of their residency training programs, covering hospital wards and emergency departments, and providing locum tenens coverage. With a general licence, residents were able to bill their provincial Health Insurance Plans for their services.

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After the 1993 licensure changes, which required residents to become certified by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada before obtaining an independent practice licence, an entire cohort of working residents and their medical services essentially vanished. This was one of the single most important policy changes that resulted in a shortage of physicians—an issue that has since then become progressively worse.

The barriers to restricted registration of residents have contributed to the dearth of available physicians to provide call, locum, and related medical services. A return to moonlighting has gained political and social validity, with the increasing scarcity of physicians, the challenges with recruitment and retention of rural doctors, and the burden of debt load on residents. As the current climate begs academia to explore models to solve these issues, moonlighting is being considered as a viable option.

Seeing the light

Moonlighting has a lot to offer. It provides residents with additional income, enabling them to repay unbearable student loans. It gives them opportunities for more clinical experience and responsibility, which enhances their educational experience. It exposes residents to communities outside the usual training sites, which facilitates recruitment to underserved areas. Moonlighting provides essential night and weekend coverage for community hospital emergency departments, and intensive adult, pediatric, and neonatal care. It enables coverage of palliative services, chronic care institutions, and all other areas in which residents are trained and competent to perform their work—including surgical assists and obstetrics coverage, in which the alternative would be *no* care.

One of the most widely cited motivations for residents to participate in moonlighting is to ease the

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The parties in this debate will refute each other's arguments in rebuttals to be published in an upcoming issue.

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burden of their loans and debts and increase their earnings,[1-3] but other motivations include refinement of clinical skills, practising independent decision making, exposure to various work environments and social responsibility[4] in the provision of services in rural areas and underserviced sectors, and positively enhancing the placement of physicians in rural practices. The literature reports a number of studies that examined the moonlighting practices of residents, especially in emergency medicine.[4-6] There are no systematic reviews that examine the effects of restricted registration on the education, performance, and well-being of residents and their families, as well as their job placement upon completion of their residency training. This lack of evidence has led to the development of a pilot project in restricted registration in cooperation with the College of Physicians and Surgeons of Ontario and the Ontario Ministry of Health and Long-Term Care.

Debunking the myths

There are several myths associated with the practice of moonlighting:

Moonlighting causes sleep deprivation, depression, substance abuse, and divorce. This is untrue. Moonlighting is not the main cause of these problems and is unlikely to be the main contributor.

Workplace compliance imposed by resident collective agreements and the hard-fought successes of restricted work hours are defeated by the right to work outside the contract. Many residents work as nonmedical professionals on the side, and that work is not regulated. At present, moonlighting, which occurs because of shortages in emergency rooms and intensive care and critical care units, is an under-the-table activity. With transparent criterion-based moonlighting, we can impose restrictions on the activity and intervene if it interferes with educational performance.

There is no educational value in moonlighting. Progressive clinical exposure and graduated responsibility are inherent parts of our educational system, and evidence indicates that these elements enhance the resident's various roles: professional, expert, scholar, manager, collaborator, communicator, and advocate.[5]

Residents do not know their limits. Residents are very concerned about legal liability and are able to decide for themselves what is appropriate. Employers have to meet regulatory requirements to ensure competency and supervision. By allowing Code 35, "Residency with Moonlighting," the Canadian Medical Protective Association acknowledges the validity of this activity.

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Competing interests
None declared

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CLOSING ARGUMENTS

- Moonlighting is a valuable activity for residents. It allows senior residents to enhance their clinical experience and provide patient care in areas where there are service shortages while earning additional income to ease the burden of their medical school debt.
- There has been no evidence to support the claims that moonlighting causes poor academic performance or harms resident wellness.
- It is wrong to muddle up the arguments of duty hours with those of moonlighting, as they are different issues.
- Robust criterion-based approval processes, such as those in our Ontario pilot program, would allow programs and regulatory authorities to stop residents from moonlighting if necessary.